

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

SHANE P.,

Claimant,

and

REGIONAL CENTER OF ORANGE
COUNTY,

Service Agency.

OAH No. L 2005110099

DECISION

On July 11, 13, September 12, 14, October 19, 24, November 7 and 28, and December 8, 2006, in Santa Ana, California, Alan S. Meth, Administrative Law Judge, State of California, Office of Administrative Hearings, heard this matter, which was consolidated for hearing with the matter of Luke P., OAH No. L2005110100.

Shelli J. Lewis, Attorney at Law, represented claimant.

Mary Kavli, Fair Hearing Officer, represented the service agency.

The matter was submitted on December 8, 2006.

ISSUE

Whether claimant is eligible for regional center services with a diagnosis of autism.

FACTUAL FINDINGS

1. Claimant is five years old and lives with his parents and two brothers in Mission Viejo, California. His mother made a self-referral to the service agency on October 2, 2002, when he was 17½ months old but since he was born prematurely, his adjusted age was 15½ months. The service agency found he was eligible for services in October 2002, and he received early intervention services until April 2004, when he turned three years of age. At that time, he was found not eligible for Lanterman Services. The family was notified of this decision and did not appeal it.

Claimant's mother contacted the service agency on July 13, 2005 to have claimant reassessed for service agency eligibility and general services. She informed the service agency that claimant had received a diagnosis of autism from Betty Bostani, Ph.D. in December 2004 and autistic spectrum disorder from Joseph Donnelly, M.D. in June 2005. After performing an assessment, the service agency determined claimant did not meet the eligibility requirements of Welfare and Institutions Code section 4512, subdivision (a). In particular, the service agency determined claimant did not have substantial handicaps in three or more of the specified areas as required by Welfare and Institutions Code section 4512, and informed claimant's mother of this determination by letter dated October 7, 2005.

It is this decision which is the basis of this appeal.

Reports

2. Marilyne Thompson is a service coordinator for the service agency in the Intake and Assessment Unit. She performed an intake assessment on August 1, 2005 and wrote a Social Assessment. She met claimant and his mother in the family home and found that claimant was receiving therapy from a therapist from the Center for Autism and Related Disorders, Inc. (CARD). She noted claimant made intermittent eye contact with her and the therapist and he spoke in sentences with good articulation and intelligibility. She noted his receptive language appeared good and observed him answer questions from the therapist appropriately. She found claimant attended to all tasks given to him despite potential distractions and played with his brother in what appeared to her to be creative play. Ms. Thompson reported that claimant attended Grace Preschool and that Saddleback Valley Unified School District (District) partially funded the placement.

Ms. Thompson considered claimant's current functioning. Regarding his motor ability, she reported that claimant was ambulatory with no gait or balance disturbance observed. Claimant could climb stairs holding the railing and did not use alternating feet to climb up, but did use alternating feet to climb down. Claimant was able to run and hop, could extend all his extremities, did not pedal a tricycle or maintain his balance on one foot, according to his mother. She reported he had fine motor deficits such as difficulty picking up small objects with his thumb and forefinger, although she observed him holding a pencil in the appropriate grasp without assistance.

Regarding self-care, Ms. Thompson reported that claimant was able to eat with a spoon and fork although he preferred to finger feed; there was some spillage with utensils due to his difficulty in holding the tableware; he could put on his shirt, shorts, underwear, and socks; he could not put on his shoes and could not button, tie, or zip his clothing; he used the toilet independently but was having night time enuresis lately; he needed assistance with showering, brushing his teeth, and washing his hands; he will attempt all tasks but needs assistance to complete them; and he will pick up toys with prompts.

As for his social/ behavioral/emotional functioning, Ms. Thompson reported claimant had received 20 hours weekly of CARD in-home services since February 2005; he generally

ignored new persons and others had to initiate interactions and if they did, he would engage; he avoided eye gaze with strangers but made good eye contact with his family members; he preferred to play alone with his twin brother and would actively avoid other children; his play was repetitive, scripted, and generally parallel; and he could play interactively with assistance and direction from others. His mother told Ms. Thompson that claimant was more heightened of the twins, he needed deep pressure to calm and regulate his behavior, the parents had to initiate affection although he would receive it, he was clingy at times and failed to respect personal boundaries, he did participate in a play group but he shared friends with his brother at school, and when they played together, they did not initiate interactions with other students. Claimant's mother described other aspects of his behavior, and frequently compared him with his brother. She did not describe any repetitive, aggressive, or self-injurious behaviors, although claimant averaged two tantrums a day when thwarted, which consisted of screaming, crying, and lying on the floor. She indicated he has difficulty learning new concepts and showed mild difficulty with transitions but was easily redirected. His mother said claimant opened and shut his eyes or placed a piece of paper in front of his eyes; she was not sure if this was self-stimulatory behavior or related to his vision problems. She reported claimant's interests were limited to Super Heroes and he was a picky eater. She indicated he was bothered by loud sounds and will cover his ears; he is sensitive to having his teeth touched, and bothered by clothing tags and mild odors. According to his mother, claimant's speech was scripted and perseverative mostly about Super Heroes, with only 30 percent original and appropriate, his speech was fragmented, he could not express concepts, he did not ask questions, and had difficulty with reciprocal conversation. Claimant understood basic gestures and facial expressions but not body language and social skills. She did not feel claimant's safety awareness was age appropriate and he had to be closely monitored at all times.

Ms. Thompson observed claimant make intermittent eye contact, he spoke in sentences with good articulation and intelligibility, his receptive language appeared to be good, he answered questions appropriately, he performed the tasks required of him by his therapist and asked for help appropriately, he was not distracted by his brother's activities, he shared his enjoyment with his therapist about a picture he had drawn, he ran around the house but was quietly redirected by his mother and he immediately complied, he fingerpainted, and he and his brother engaged in interactive play after the therapist left.

Regarding cognition, Ms. Thompson reported the District assessed claimant and obtained a mental development score within the average range. On the Wechsler Preschool and Primary Scales of Intelligence (WPPSI-R) performed by Dr. Bostani in 2004, claimant achieved a performance IQ of 87, verbal IQ of 94, and a full scale IQ of 90, and that claimant was within the bottom of the average range of overall intellectual functioning. She noted results on other tests as well.

As for communication, Ms. Thompson reported the District's assessment for special education, and his speech and language was within the average range. Dr. Bostani tested his language using the Preschool Language Scale-4th Edition (PLS-4), and found his scores were average. Ms. Thompson found claimant's eye contact varied with the person and the environment, he spoke in sentences with good articulation, his vocabulary was average, he

engaged in scripted and perseverative speech, he understood simple conversations, and he could follow a two-step command.

3. On February 21, 2003, Ira Lott, M.D., Director of Pediatric Neurology at UCI, wrote a letter following his evaluation of claimant. His parents sought a second opinion regarding possible autistic spectrum disorder. Claimant was then 22 months old. Dr. Lott noted that claimant's older brother and a paternal uncle had autism and claimant had delayed expressive and receptive speech.

Dr. Lott indicated claimant was showing a number of atypical behaviors seen in autistic spectrum disorders including delayed speech, poor eye contact, and some repetitive behaviors. Claimant did not display any stimulus sensitivity and the level of his social interest was not yet clear. Dr. Lott felt there was enough symptomatology, particularly in light of the family history, to support an initial diagnosis of autistic disorder. He recommended home-based therapy.

4. On January 29, 2004, Susanne Tasin, M.S., the case supervisor, and Doreen Granpeesheh, Ph.D., Clinical Director, wrote a regional center initial report. They noted claimant then attended Rainbow Kids, which provided one hour per week of physical and speech therapy. They found he showed delays in language development, gross motor development, social development, and self-help skills. They indicated claimant displayed maladaptive behaviors—aggression, tantrum behavior, and non-compliance—that required behavior intervention and parent training. They recommended claimant continue to receive speech and occupational therapy and social groups. They further recommended claimant begin receiving six hours of initial parent training and two hours per month of supervision after the initial training, and that a qualified ABA consultant provide training to the parents to implement and monitor a behavior management plan to increase appropriate behaviors and decrease inappropriate behaviors. They indicated the program would continually evaluate his progress. Finally, they recommended that claimant be assessed yearly.

5. Therapists from Rainbow Kids wrote an Infant-Toddler Discharge Report dated March 26, 2004 summarizing claimant's testing and progress while he attended the program. He was then 35 months old. Their diagnosis was developmental delay. Claimant had been receiving one hour weekly of speech therapy and one hour weekly of physical therapy for one year and had made "tremendous progress" since the last report in October 2003.

Testing showed claimant was at the 32 to 34 month level in cognition. In receptive language, claimant was at the 27-month level based upon the PLS-3, he was at the 29-month level in expressive language, his fine and gross motor skills were at the 28-month level, and his social-emotional level was at 34 to 36 months. They determined his self-help skills were at the 24-month level, which represented a 30 percent delay. They determined he demonstrated typical performance in the areas of general, visual, tactile, vestibular, and oral sensory processing, but atypical performance in auditory processing. They indicated he frequently ignored people when they were talking to him, he sometimes took a long time to

respond to his name, his eye contact was improving, but he was easily distracted and demonstrated a decreased attention span.

The therapists recommended claimant be discharged from therapy with Rainbow Kids because he was about to turn three years of age and that he continue socialization with peers in a regular preschool program. They pointed out his gross motor skills had improved over the previous few months but still showed a 20 percent delay, as did his fine motor skills which had improved only slightly. They believed claimant would benefit from a therapy program that continued to address his fine and gross motor skills.

A review of his previous goals showed most had been met.

6. The District tested claimant on March 5 and 29, 2004, observed therapy on March 25, and wrote a Multidisciplinary Assessment Documentation dated April 19, 2004.

a. Claimant was referred for special education by the service agency. Claimant was observed during speech and language therapy at Rainbow Kids. The District's assessment included administration of a number of tests: on the Bayley Scales of Infant Development-II, claimant's scores were within normal limits on the mental scale and mildly delayed in motor skills; on the Autism Diagnostic Observation Schedule (ADOS), claimant's scores did not meet the criteria for an ADOS classification of autism or autism spectrum disorder; on the Child Development Inventory (CDI), which is based on parental responses, it appeared claimant was clumsy, walked or ran poorly, his speech was difficult to understand, he acted immaturely, he could not sit still, was hyperactive and disorganized, was demanding and disobedient. On the PLS-4, his scores were in the average range, and on the Goldman-Fristoe 2 Test of Articulation, his score was average. On the Comprehensive Assessment of Spoken Language (CASL), his scores were reported in age-equivalent and as a standardized scores; he was between three and nine months delayed on basic concepts, syntax construction, and pragmatic judgment.

The District evaluators concluded that claimant did not meet the educational criteria for autism, based upon standardized assessment, observation, review of records, and parent report. They indicated the results of the evaluation suggested an overall developmental functioning between 25 months and 37 months, with specific skills ranging from 19 months to 36 months. According to the evaluators, claimant demonstrated strengths in the area of cognitive skills and inconsistent weaknesses in expressive language. They recommended special education with speech and language impairment as the eligible condition. As the functional description of the handicapping condition, they described inconsistent weaknesses in expressive language in the areas of syntax, morphology, and pragmatics.

b. The District also performed a school-based occupational therapy assessment on March 29, 2004. Claimant's mother's concern was with claimant's fine motor skills, and balance. The assessment took an hour and fifteen minutes and included standardized testing, a questionnaire, clinical observation, parent report, and chart review. Claimant was compliant during testing, he easily transitioned from one activity to another, and he demonstrated appropriate eye contact. His attention was appropriate until the end of

the assessment. The report described what claimant could and could not perform but contained no findings or conclusions, other than a statement that claimant's fine motor skills fell within the average range.

7. The District asked Paul Alan Does, Ph.D. and a licensed psychologist, to evaluate claimant to provide opinions and recommendations regarding the nature of his challenging behavior. He visited the home on October 29 and November 17, 2004, visited his preschool class on November 17, 2004, and conducted a record review. He interviewed claimant's mother and summarized the information she reported to him. He also described his observations in school and at home.

Based upon the information provided to him and his observations of claimant, Dr. Does concluded claimant exhibited some challenging behaviors, primarily in the form of noncompliance and tantrum behaviors such as screaming, crying, and falling to the ground, and they could occur several times a day. He noted they occurred when claimant was at home or with his mother in the community, and they functioned as a means to escape non-preferred demands and to gain maternal attention. Dr. Does reviewed reports from CARD which indicated claimant exhibited noncompliance, tantrums, and aggression. Dr. Does, however, observed only mild noncompliant behavior. Other information suggested to him that claimant's noncompliance might be significant enough to create some difficulties at home, but not in clinical or educational settings.

Dr. Does agreed with CARD that the primary focus of intervention should be on preventative strategies to organize the home environment so as to reduce the difficulties that arose during the morning routine and other hectic transitions. He felt the issue in the home was the ability of claimant's parents to implement strategies correctly and consistently, and he recommended that any behavioral consultation be focused on assisting the parents. He believed consultation should be delivered on a short-term basis.

8. On May 9, 2005, Beth Ballinger, O.D., wrote a letter to claimant's parents following an examination. She found he demonstrated oral motor apraxia, dysarthria/slurred speech, fine motor dysfunction in areas other than oral motor integrity, intermittent right eye exotropia at near and frequently closes his right eye or turns his head to his right shoulder to favor his left eye when involved in near point visual demands. She also found he demonstrated 15 to 20 prism diopters of right exotropia depending on visual fatigue and duration of the visual demand. She recommended orthoptic therapy to remediate his exotropic visual condition which negatively impacted his visual development and daily living skills. The therapy was to consist of two hours per week to address his fine visual-motor binocular dysfunction. She indicated without proper therapy, claimant would have difficulty in visual acquisitions for clear single binocular vision which will interfere with visually directed motor demands for movement and he would not outgrow the dysfunction. She felt there was an excellent prognosis with immediate attention.

Dr. Ballinger began treating claimant in January 2006, and wrote a report of her assessment of him on February 28, 2006. She recounted the therapy claimant had received

and the diagnoses, including autism and neuro-developmental dysfunction, oral-motor dyspraxia, and dysarthria/slurred speech.

Dr. Ballinger performed a visual examination. She found his visual acuity was 20/20 at distance and 20/25 at near point, he was slightly farsighted and had a small amount of astigmatism. She indicated glasses had not been prescribed until a course in vision therapy designed to improve visual-motor competency.

As far as eye movement, Dr. Ballinger determined claimant followed a target by moving his head instead of just his eyes and had difficulty differentiating fine motor eye movements from larger motor head movements. She noted he might overshoot his target when he moved his head, and peripheral distracters interfered with his ability to accurately monitor and predict where his eyes must move to when looking at visual targets. She felt this would impact his reading accuracy, negatively impact his ability to rapidly process information and his comprehension and require him to take more time to process information, interfere with other movements, provide him inaccurate information, and cause fatigue.

Dr. Ballinger found claimant demonstrated significant focusing instability in that his focusing ranges over time interferes with his ability to sustain visual attention for fine detailed discriminations. She felt this was a major contributing factor that would interfere with proper visual uptake over time and it already contributed to fragile sustainable visual attentional abilities. She also found he demonstrated significant eye teaming dysfluency, and will cover one or the other eye when involved in near point visual demands. She noted his variable double vision and eye covering were significant factors as to why he visually disengaged from near point tasks and avoided sustained demands which might overwhelm him. She pointed out claimant also had a history of gross and fine motor deficits as well as deficits in bilateral coordination, and visual coordination was an aspect of his global motor difficulties.

Dr. Ballinger administered tests designed to measure claimant's visual information processing. Claimant's scores were very low in the areas of visual discrimination, visual memory, visual figure ground, visual spatial relationships, form constancy, and sequential memory, and average only in visual closure.

In summary, Dr. Ballinger concluded claimant demonstrated difficulty maintaining accurate and efficient eye movement free of head movement, focusing accuracy sustained over time, eye teaming integrity at near point with sustainable duration, visual attentional maintenance, visual discrimination, visual-motor integration, visual spatial relationships, visual form constancy, visual sequential memory, visual ground, and possibly auditory sequential memory integrity. She believed these difficulties could have a profound impact on visual demands as they become more complex and sophisticated, and negatively impact his visual attention and processing speed, thereby negatively affecting school functioning. She believed many of the important foundation skills could be redeveloped and interwoven into his life, thereby expanding his opportunity for more educational success. She gave a list of recommendations including Optometric Vision Therapy and those to be used in an

educational setting such as having him sit in the center of the front row in class, working in a quiet environment without distractions, allowing him more time, and so forth.

9. On June 10, 2004, Joanne G. Hein, M.S., a speech-language pathologist, wrote an evaluation report relating to claimant's language functioning. She reviewed prior reports and administered a series of tests. She found claimant presented with a varied profile of language skills, from the average range for his age on one measure to the severely impaired range on other tasks. She reported his greatest difficulty involved following oral directions with pictures, producing age-appropriate word order and sentence structure, and his articulation in connected speech, but she added he had made substantial growth in language development over the past several months. She also wrote she did not observe any atypical behaviors attributable to autism during the evaluation. She concluded he presented with an expressive-receptive language impairment and articulation disorder, with difficulties with social language appearing to relate to those diagnoses, and with his developmental delays and strong family history, she believed he remained at-risk for functioning along the autism spectrum.

Ms. Hein believed claimant's prognosis was excellent for increasing receptive and expressive language, articulation, and social communications to age-level functioning following a course of therapeutic intervention. She recommended two hours per week of therapy in the area of speech-language pathology for two to three years, plus consultation among treating professionals and the family.

On March 10, 2006, Ms. Hein performed a second evaluation and wrote a report dated April 10, 2006. The evaluation was designed to determine the progress claimant had made since the initial evaluation and to make recommendations for further treatment. She administered the Clinical Evaluation of Language Fundamentals-Preschool-Second Edition (CELF-P2P) to obtain a better understanding of claimant's receptive and expressive language functioning. Claimant's scores were in the average to low average range for core language (96), receptive language (88), expressive language (100), language content (95), and language structure (94). He scored very low on the criterion score subtests. On the Goldman-Fristoe Test of Articulation-2, claimant's score of 95 was in the average range.

Ms. Hein reported claimant presented with a varied profile of language skills, from the average range for his age on some measures to the severely impaired range on other tasks. She felt his greatest areas of speech-language weakness were difficulty involving inconsistent attention to language-based input, organizing his ideas for clear verbal expression, managing auditory and visual input simultaneously, producing intelligible speech in all contexts, and his social-pragmatic skills. She felt the prognosis was highly favorable for increasing receptive and expressive language articulation and social communication skills to age-level functioning following a course of team-oriented therapeutic intervention. She estimated two hours per week of direct therapeutic intervention in the area of speech-language pathology for one to two years, and one hour per week of consultation among treating professionals and the family.

10. On May 5, 2004, Miche' Almeida, M.S., a speech and language pathologist, wrote a consultation summary following a consultation the previous day prompted by claimant's mother's concern regarding his speech development and oral motor skills. Ms. Almeida judged claimant's articulation skills to be approximately 68 percent intelligible and indicated he exhibited the presence of phonological processes, reduced diadochokinetic rates, and reduced speech clarity at the polysyllabic word, phrase, and sentence level. She added this his articulation skills were further compromised by oral motor muscle weakness in his jaw, lips, and tongue.

Ms. Almeida did not do any formal language testing but she did analyze claimant's spontaneous language and she determined that he demonstrated difficulty sequencing syllables in nonsense syllable tasks and in connected speech. She felt his motor planning difficulties directly impacted upon his ability to easily and clearly express himself, and that treatment should incorporate the principals of motor learning, which include the need for multimodality input and practice. She recommended two hours per week for six months to a year for individualized, intensive treatment within the private clinic.

11. On May 20 and June 9, 2006, Elaine S. Ito, Ph.D., a licensed psychologist, performed a psychological evaluation of claimant to assess his current functioning and assist in the determination of his eligibility for regional center services. She administered a series of standardized tests, reviewed previous evaluations, and observed his behavior. The evaluation took place in claimant's home, and his mother provided the relevant history.

In her report under the heading of "Behavioral Observations," Dr. Ito indicated claimant smiled and reciprocated her greeting when she opened the door for her. Claimant introduced himself to her and called for his mother at Dr. Ito's request. Dr. Ito observed claimant get into an argument with his brother when they were eating breakfast and she noted he exhibited appropriate eye contact. During a one-to-one situation with her, Dr. Ito observed that claimant appeared to be very inattentive and he frequently "gazed off" to his side, but did not appear to be looking at anything in particular. Between test items, claimant would play with a toy and when he was engaged in a task, he made excessive noises. She often had to redirect claimant back on-task. She noted claimant did not look when she was giving him a verbal instruction and would briefly look up when he was talking to her. She observed that he persisted on tasks with encouragement and did not get frustrated as the tasks became more difficult. She described him as "quite engaging." Dr. Ito concluded that because claimant was able to focus, with constant redirection, the test results were probably a good estimate of his current overall cognitive functioning, but she cautioned that specific scores might not be predictive of his long-term functioning due to his young age.

On the Stanford-Binet, claimant's scored 98 on the verbal and 93 on the nonverbal tests, and his full scale IQ was 96. His scaled scores on the subtests ranged from seven to twelve (the mean is ten). His scores on fluid reasoning, knowledge, quantitative reasoning, visual-spatial processing, and working memory ranged from nine to eleven, with a mean of ten, and scaled scores of 94 to 103. Claimant's cognitive abilities therefore fell within the average range. On the Test of Visual-Motor Integration (VMI), claimant had a standard score of 59 placing him below the first percentile and with an age equivalent of two years,

nine months. Dr. Ito indicated this was in the moderately delayed range. On the Adaptive Behavior-Assessment System, Second Edition (ABAS), a test which used information provided by claimant's mother, his general adaptive composite was 65, his conceptual composite score was 61, his social composite score was 81, and his practical score was 54. These scores placed claimant in the mildly to moderately delayed ranges and at or below one percent of his age peers. Dr. Ito reported the considerable information claimant's mother provided which supported these scores.

Dr. Ito interpreted the VMI as showing possible weakness. She noted his pencil grip was awkward, and his grip was somewhat weak. Claimant was better able to reproduce simple geometrical shapes such as a line and circle if he were provided with both a visual picture as well as a motor response from which to copy, but he could not draw a cross, square, or triangle, and his lines were light and wavy. She felt these delayed skills were not unexpected given his reported difficulties with motor planning and visual perceptual deficits.

Based on claimant's scores on the Stanford-Binet test, Dr. Ito ruled out mental retardation, but she interpreted claimant's scores on the ABAS as indicating there may be factors that are interfering with his reaching his potential in terms of functioning. She indicated claimant's behaviors during the evaluation might provide clues to identify the underlying factors, including significant attention issues (his "gazing out" and her need to redirect him back to task frequently), seeking out sensory input, global motor planning issues, clumsiness, struggling with visual perceptual skills, and processing difficulties.

In Dr. Ito's view, claimant would benefit from interventions to address the individual behavioral concerns, such as individualized attention to help him achieve his academic goals despite his attention issues and difficulty with auditory information, and continued occupational therapy to address the fine motor difficulties, motor planning issues, and sensory integration deficits. She could not determine if his current delays in adaptive functioning were suggestive of a lifelong disability, and she hoped that with his cognitive strengths, his daily functioning would improve. Dr. Ito believed claimant's progress should be closely monitored over time. She felt many of his deficits could be explained by his diagnosis of autism. She concluded he presented with a very complex diagnostic picture resulting in complex intervention needs. She recommended continued services to facilitate his pragmatic language and conversational skills, continued occupational therapy, continued participation in a classroom setting that provides individualized attention, and verbal prompting.

12. Dr. Joseph Donnelly is a pediatrician at the UCI Medical Center in Irvine.

a. On June 30, 2003, Dr. Donnelly wrote a letter describing his consultation. He indicated that since he last saw claimant, claimant had made "gains overall" including using about 15 words, following some one-step commands, and pointing to body parts. He believed claimant's receptive language was about four months behind and his expressive language about six to eight months behind. He noted claimant was receiving early intervention through Rainbow Kids and an hour of physical therapy and an hour of

individual speech and language plus an hour of peer group speech and language to be arranged.

Dr. Donnelly indicated claimant had global delays involving expressive language. He did not feel claimant showed features of autism but felt further neurodiagnostic testing and continued early intervention and developmental monitoring were necessary.

b. Dr. Donnelly saw claimant again five months later and wrote a letter dated November 4, 2003. He summarized information he received from claimant's mother and from Rainbow Kids. He noted claimant was currently making progress with early intervention and was "talking quite a bit." He described claimant as somewhat inattentive and distractible, but he did point, made eye contact, played, and was interactive.

In Dr. Donnelly's opinion, claimant was making progress in all areas as documented by parental report and testing through Rainbow Kids. He did not believe claimant met the DSM-IV criteria for an autistic disorder. He indicated claimant was inattentive and somewhat distractible, and the possibility of his having mild autism had to be monitored. He felt that in view of claimant's global delays including cognition and language as well as inattentiveness and some behavioral issues, that his mother needed more assistance with behavioral intervention as well as speech and language intervention.

c. Dr. Donnelly did not see claimant again until June 8, 2005, when claimant was four. He noted claimant "made many developmental gains, but there are significant concerns." He noted claimant was evaluated by Dr Betty Bostani, a psychologist, in the fall of 2004 who felt claimant met the criteria for autistic disorder. He reported that claimant was then in a CARD 20-hour per week behavioral intervention program and was receiving speech and language therapy. He indicated claimant was making progress in all areas, especially with language, and was more intelligible and having fewer tantrums. He noted claimant had been having severe problems with transitions, and Dr. Dores had been brought in by the District to assist.

Dr. Donnelly described claimant as a special needs preschooler who as time went by continued to evidence some difficulties in social interaction, poor eye contact, and lack of pragmatic language skills out of proportion to other language deficits, scripted play, and a tendency to over focus on super heroes. Based on the DSM-IV, he concluded claimant met the criteria for an autism spectrum disorder and seemingly mild autism. During the current evaluation, Dr. Donnelly noted claimant had some problems with eye contact, prosody of language, and repetitive behaviors, and was inattentive and distractible, though he did not require psychotropic medication.

d. Dr. Donnelly saw claimant on September 6, 2006. He indicated claimant was a special needs student with cerebral dysfunction marked by autism, global delays, and elevated CPK in the past with motor concerns and more recent "gazing out" spells, and an abnormal EEG. Claimant's parents noticed claimant gazing out in 2006 and that he did it three to four times a day, with the episodes lasting a few seconds. Claimant's father indicated to Dr. Donnelly that claimant needed to be called three or four times during

one of these spells. Dr. Donnelly indicated the EEG done on August 4, 2006 was abnormal but claimant had not had any seizures and was not taking any anticonvulsant medication. Dr. Donnelly and claimant's parents felt he had been making progress in all areas.

Dr. Donnelly's impression was that while claimant had made "a great deal of progress but continues to demonstrate significant deficits despite normal cognitive ability and lack of scatter. Weaknesses exist in language function including pragmatics and articulation, learning, visual motor abilities, social skills, adaptive areas, and fine and gross motor coordination." He could not determine what was the cause of claimant's "gazing out" and wanted to make sure it was not seizures. To this end, he indicated he wanted to set up a phase I video EEG, among other things.

13. Dr. Betty Bostani is a licensed clinical psychologist. She assessed claimant on September 30 and October 25, 2004, and observed him at home on December 8, 2004. She wrote a psychological assessment report after the observation. Dr. Bostani administered a number of psychological reports, but did not review any other reports or interview anyone other than claimant's parents.

Dr. Bostani administered the WPPSI-R. Claimant achieved a performance IQ of 87, a verbal IQ of 94, and a full scale IQ of 90, which placed him in the average range in overall intellectual functioning. On the Leiter International Performance Scale—Revised (Leiter-R), a test of intellectual ability, memory, and attention, claimant scored in the average to below average range in visualization and reasoning, and in the average range in attention and memory.

Dr. Bostani administered the PLS-4, which measures receptive and expressive language skills. Claimant's score of 109 in auditory comprehension placed him at the age equivalent of three years, eight months, and his score of 107 in expressive communication placed him at the age equivalent of three years, seven months. His total language score of 108 placed him the age equivalent of three years, seven months.

On the Behavior Rating Inventory of Executive Function—Preschool Version (BRIEF-P), a questionnaire for parents and teachers for the assessment of executive function behaviors in the home and preschool environments, claimant's scores on the scales of Inhibit, Shift, Working Memory, and Inhibitory Self-Control Index, Flexibility Index, and Emergent Metacognition Index placed him in the area of potentially clinically significant dysfunction. He scored in the average range in Emotional Control and Plan/Organize. His overall global executive composite score placed him in the area of potentially clinically significant dysfunction.

Dr. Bostani used the Vineland Adaptive Behavior Scales (VABS) which is a structured interview administered to parents to measure claimant's adaptive behavior in the domains of communication, daily living skills, socialization, and motor skills. Claimant's scores were adequate in communication and moderately low in daily living skills, socialization, and motor skills. His composite was moderately low.

Dr. Bostani used the Clinical Autism Rating Scale (CARS) to assess whether claimant was autistic. Claimant's score of 30, according to Dr. Bostani, met the diagnostic criteria for autistic disorder in the DSM-IV. She placed him in the mild range.

Dr. Bostani indicated claimant's IQ scores were significantly impacted by impulsivity and poor motor planning on one particular task. She noted he tended to perseverate on specific topics. She concluded that claimant required structure, with clear and consistent expectations and consequences, and if given appropriate intervention, is a child with considerable potential to make progress in all of areas of deficit, and function independently in the community. She recommended he receive an in-home behavioral intervention in the form of ABA to include discrete trial teaching. She recommended participation in a typical classroom, and other interventions as well.

14. Dr. Bostani performed a second assessment of claimant in April and May 2006. This time, she reviewed other, recent reports, and administered a number of tests. On the WPPSI-III, claimant's scores increased, with him achieving of full scale IQ of 97, a performance IQ of 101, and a verbal IQ of 104. However, his processing speed was borderline at 71. Dr. Bostani observed that claimant evidenced significant progress in all areas of intellectual functioning relative to his previous assessment. However, on the BRIEF-P, claimant's scores remained low, with only Inhibit and Shift in the average range, and all the other scores as well as the global executive composite were well below average. Dr. Bostani noted the executive functions increase proportionately with age, and therefore claimant continued to require development in the areas of inhibitory self-control, flexibility, and emergent metacognition.

Dr. Bostani administered the Test of Pragmatic Language (TOPL) to assess the pragmatic or social dimension of language. Claimant scored in the below average range with an age equivalent of four years. On the Leiter-R, claimant scored in the average range except forward memory, which was below average. On the Vineland, with claimant's mother as the informant, claimant's scores were in the adequate to moderately low area.

Dr. Bostani described her observation of claimant at school: when he was outside, he varied his activity and who he played with appropriately, his verbal interactions were appropriate and frequent though unclear at times, he evidenced observational learning and imitated the actions of other children during play, played with his brother and returned to play with his classmates with ease, and did not seem to need the shadow aide's assistance for social interaction. On motor skills, claimant did not attend to the teacher demonstration and did not do well in any of the activities. When the class was in the chapel, claimant participated with clapping on some songs and his clapping appeared awkward, he did not imitate the actions or join in imitating the leading child's prayer, and he attended well during a bible story. Dr. Bostani determined that claimant played very well with peers, he initiated ideas and engaged in very appropriate dialogue, his tracing appeared appropriate but on writing on his own, he did poorly. She noted he asked appropriate questions during circle time but was also distracted by talking by a peer.

Dr. Bostani reported claimant's teacher indicated claimant had difficulty with fine motor tasks and gross motor tasks, he had trouble sequencing and categorizing, he gazed off at times and the teacher was not sure if he was listening, his play and socialization had improved significantly, he had a great sense of humor and was mindful and thoughtful, and he needed assistance to focus better on instructions.

Dr. Bostani also described her home observation which took place during his home CARD program. She indicated he was very responsive to learning the remaining higher order curriculum in an environment that naturally lent itself to generalization.

Dr. Bostani concluded that claimant had excelled in most areas of his home program and had made considerable gains in his cognitive functioning since his previous assessment in 2004. Nevertheless, she believed there was a continued need for progress in the various areas of deficit identified in her report and other assessments (vision, speech, OT) and he continued to contend with a number of impairments that hindered his ability to function appropriately and independently in everyday life. She indicated that through his program, claimant had achieved typical functioning in many areas and he had considerable potential to make progress in all of his remaining areas of deficit.

Dr. Bostani identified executive functioning, visual memory, adaptive behavior, pragmatic language, theory of mind (perspective taking) and gross and fine motor skills as challenging areas. In addition, other testing disclosed challenges in the areas of language development, global visual processing, sensory integration, and motor coordination. She noted that CARD had addressed effectively many of his areas of need. She recommended that the program continue for at least 20 hours a week of one-to-one ABA procedures. She further recommended visual therapy. In school, Dr. Bostani indicated claimant required assistance with attention/focus, participation, gross and fine motor skills, and significantly delayed written skills. She wanted the children with whom claimant was placed to be appropriate models, and she wanted him placed in a small enough classroom to have the opportunity for greater individualized attention. She suggested a junior kindergarten classroom and a trained shadow aide from his home program. Finally, she recommended parent training.

15. Dr. Jim W. Lam, a family practice physician, in a letter dated January 31, 2005, diagnosed claimant with neuro-developmental dysfunction due to premature birth at thirty-two weeks gestation. He indicated claimant had undergone lingual frenuloplasty but still had dysarthria/slurred speech due to his neurologic impairments. He noted speech-language pathologists had diagnosed him with oral-motor apraxia. He indicated that it would be difficult for claimant to outgrow his verbal apraxia and recommended speech therapy three times a week.

16. The District conducted a multidisciplinary assessment in May 2006 for a special education update

a. The district issued a report on June 6, 2006 and signed on June 8 by Betsy Munoz, School Psychologist. A number of tests were administered over the four- day evaluation.

On the Kaufman Assessment Battery for Children, second edition (KABC-II), claimant's cognitive ability was placed in the average range.

On the CDI, parent report resulted in a rating of general developmental skills at the two year, three and a half month level which is significantly delayed. When claimant's scores were compared to his 2004 scores, they showed only a two-month gain in overall development in two years.

On the Test of Auditory-Perceptual Skills-Revised (TAPS-R), claimant's score was in the low average range of functioning. All of his subtest scores were in the average range except auditory number memory forward and auditory number memory reversed which were low average.

On the CDI related to fine motor skills, parent report showed claimant's skills fell at the two-year, three month level which was significantly delayed. He could draw or copy horizontal or vertical lines, a complete circle, cut paper with scissors, and build a tower with eight or more blocks. He could not scribble in a circular motion, place single pieces in a puzzle board, turn pages of a book one page at a time or hold a crayon somewhat like an adult. He was observed to flip pages of a book and manipulate small objects, and explore the toys and activate them correctly.

As for gross motor skills, parent report placed claimant's ability at the 20.5-month level, which is significantly delayed. Claimant could do a forward somersault, walk up and down stairs, jump from steps, climb a ladder and slide down a slide, and ride a tricycle. He was able to walk without tripping or falling and was observed on the playground running a straight line, climbing a cargo net, and climbing up stairs.

The CDI also asked claimant's parents about his self-help/adaptive skills, and their report placed claimant at the eighteen-month level. According to his parents, claimant could eat with a spoon but not a fork and spilled a lot, he could drink from a cup, he did not take responsibility for dressing, he could not remove his socks, did not try to take off his shoes, could not zip or button, and could put on and take off an unbuttoned shirt. He was fully toilet trained. He needed help and prompting with independence skills, such as bathing, washing his face and brushing his teeth, but was able to wash and dry his hands by himself.

On the Scales of Independent Behavior-Revised (SIB-R), claimant's functional independence as reported by his teacher was age appropriate, with an age equivalency of four years and eleven months.

Ms. Munoz assessed claimant on four different days. During the assessments, claimant was hesitant at first to separate from his mother but later separated and willingly joined the examiner. Claimant's level of cooperation and interest in the assessments varied

and he did not appear to put forth much effort. He was not easily distracted, restless, or overactive, but it was often difficult to gain his attention. His eye contact was very limited and his affect was usually flat. He rarely initiated interaction.

At school, the examiner observed claimant participate in activities and interact appropriately with other children and laughed at jokes and made his own jokes. He engaged in reciprocal conversation with his teacher, both responding to her questions and asking more questions. He often needed prompting. His play skills appeared commensurate with his classmates and at one time, he pretended to be a fireman. His play skills varied and he was more engaged in unstructured settings. His skills were limited by his lack of sustained attention and interest. He did engage in representational and symbolic play, and preferred to play by himself. At home he displayed good eye contact and responded appropriately to questions and asked relevant questions.

On the CDI related to social emotional, parent report placed claimant at the 24-month level which is significantly delayed. His parents reported scattered skills and that claimant did not show affection or greet people, did not obey when asked to do something, and did not understand or respond well to correction.

On the ADOS, the results suggested claimant met the criteria for a classification of autism due to observed deficits in his communication and reciprocal social interaction. Behaviors noted included his inability to participate in a reciprocal conversation, limited social overtures, unusual eye contact, limited facial expression directed to others and limited reciprocal social communication or interaction.

On the Achenbach Child Behavior Checklist completed by claimant's mother, claimant's scores on the problem scales and emotionally reactive scales and attention were borderline, and his scores on the somatic complaints, withdrawn, affective problems, anxiety problems, pervasive developmental problems and internalizing problems scales were in the clinically significant range. On the Caregiver-Teacher report form, claimant's teacher scored him in the normal range except withdrawn, pervasive developmental problems and internalizing problems, which were in the borderline range.

b. A speech and language pathologist issued a report on June 8, 2006. A number of tests were administered and a record review was conducted.

On the CELF-PS2, a checklist completed by claimant's mother that assists in evaluating a child's pragmatic behaviors in relation to social expectations for communication in a variety of situation, claimant's score did not meet the criterion score for his age. A CDI was administered with claimant's mother as the informant. His social age placed him at two years, his expressive language age at two years, five months, and his language comprehension age at two years, five and a half months. On the CASL, which measures the processes of comprehension, expressions and retrieval, claimant scores were in the normal range, except sentence completion which was in the borderline range. On the Preschool Language Assessment Instrument (PLAI-2), which assesses the ability of a preschool child to meet the demands of classroom discourse, claimant's scores were in the average range.

Claimant's score on the Assessment Link between Phonology and Articulation-Revised (ALPHA), a standardized instrument that provides two assessments using a sentence imitation format, was significantly low.

The report concluded that claimant was demonstrating receptive and expressive language abilities within the range of age-expectancy but he needed to have his attention focused and distractions minimized. It noted he benefited from being given extra time to respond but he exhibited numerous atypical sound production errors that compounded in connected speech to hinder the intelligibility of his speech. It also found that social pragmatic communication/interaction functioning deficits significantly affected his ability to communicate and sustain interactions effectively with others.

c. A Woodcock-Johnson Test of Achievement was administered to claimant on May 16, 2006, with the results contained in a report written that day. He scored in the average range in letter-word identification, passage comprehension, picture vocabulary, applied problems, and academic knowledge. His score on understanding directions was low average (88) and was significantly low in spelling (69). He was unable to complete the word attack subtest. The examiner noted there were several brief periods, each lasting several minutes, when she could not get claimant to attend. She believed he scored in the average range for his age expectations on all the subtests except spelling.

d. An occupational therapy assessment was performed by the district that included a clinical observation, administration of a test, and a records review. Fine motor testing placed claimant's grasping skills in the ninth percentile and his visual motor skills in the 16th percentile. He did not present with sensory deficits or sensory motor deficits that would impede him from academic performance. However, concerns in the area of fine motor skills, self-care, visual motor skills, and strength and endurance were apparent. Occupational therapy was recommended.

e. An adapted physical education assessment determined that claimant's distractibility and decreased attention to task combined with physical impairments in strength, balance, and gross motor skills limited his ability to safely and independently negotiate his environment (stairs, obstacles, and stopping quickly when running) and therefore recommended he receive direct educationally-based physical therapy intervention once a week for 45 minutes to improve safety and independence within his school environment.

17. On June 1, 2006, Susie Smethurst, a workshop supervisor wrote an IEP Recommendations for CARD. The recommendations included placement in a regular preschool classroom, nine hours per week of a shadow aide trained by CARD, three hours per month of CARD supervision for the regular school year, 20 hours per week of one-on-one intervention, including ten hours of CARD behavioral intervention and ten hours of in home vision therapy supervised by Dr. Ballinger, completion of a fast forward language program, and annual measurement of his skills.

In June 2006, Heather Schmidt, a therapist with CARD, wrote a report. CARD had been providing 20 hrs per week of independent therapists and three hours per month of supervision, all of which was privately funded. She indicated the behaviors observed were tantrums and non-compliance, but because of the low rate of occurrence, they were no longer tracked. However, claimant's parents reported these behaviors occurring in the home setting. Tantrums were defined as crying and falling on the floor and non-compliance was not following an instruction within ten seconds. The behaviors were addressed with techniques including extinction and redirection. She indicated behavior management techniques were taught to claimant's parents.

Ms Schmidt wrote that claimant attended a preschool for three hours a day, three times a week, and was in a typical classroom with a full-time shadow aide. The aide reported that claimant had a group of friends at school and appeared to be more assertive in the school setting compared to the home setting. The goals listed were to increase social skills, parent training, improve academic skills including language and mathematics concepts, improve gross and fine motor coordination, and generalization of skills. She described how the therapists taught the various subjects.

18. On June 27, 2005, Susanne Smith Roley, an occupational therapist, performed an evaluation of claimant to assess his development and determine the need for occupational therapy services. It was a two-hour assessment. She performed standardized assessments, observed him, reviewed records, and obtained a parent report.

The majority of claimant's test scores fell below one standard deviation from average and indicated areas of concern. She believed his profile was similar to children exhibiting visual and somatosensory-based dyspraxia. He scored in the typical range on the manual form perception and constructional praxis, but scored significantly low on space visualization, figure ground, and design copying. He had significant difficulty with ocular motor control and coordinating his eyes, head, and body movements. He had difficulty tracking.

In the area of auditory processing, claimant's mother reported he had difficulty understanding what other people said and claimant appeared not to hear certain sounds. His test score on the praxis on verbal command test was significantly low, indicating he had difficulty following unfamiliar two-step commands.

On tactile discrimination, claimant scored significantly low on all tests. These tests are designed to test his ability to localize body parts through touch and distinguish objects through touch. Ms. Smith Roley reported claimant scored significantly low on the kinesthesia tests and seemed to have somewhat poor proprioceptive awareness for grading his strength, raising and lowering his body, and positioning himself in a chair.

Ms. Smith Roley reported claimant had a history of delayed gross motor skills, and he scored in the below average range on the bilateral motor coordination test, sequencing praxis, and standing and walking balance tests which was significantly low. Clinical observations revealed poor integration of basic neuro-motor abilities. Claimant's fine motor skills scores

were significantly low and he had significantly poor ocular motor control. Claimant scored in the below typical range on all praxis tests. These tests suggested his ability to figure out the nature of a game and how to adapt and organize his actions would be impacted.

In summary, Ms. Smith Roley indicated the evaluation showed claimant had significant sensory integration and praxis difficulties, specifically in the areas of somatosensory and vestibular process and motor planning. She reported he had difficulty in fine and gross motors skill development affecting his coordinated movements, and that made it difficult for him to perceive, coordinate, and adjust his actions and make rapid motor accommodations to changes in his environment. She indicated claimant had significant processing and motor difficulties impacting his performance skills and routines, and shows deficits in most areas of information processing from his primarily sensory learning channels. She wrote that claimant had difficulty efficiently modulating and discriminating information from the tactile system and he is not able to accurately localize and discriminate tactile information. She felt claimant was under-responsive in his vestibular and proprioceptive systems which work together to allow individuals to know where they are in space and organize their movements. She indicated claimant had difficulty with motor planning and refining his movements, particularly when things are complex or moving too rapidly and that his gross motor skills were delayed and he was slow to acquire new motor skills. Finally, she reported claimant had deficits in his ability to perceive, modulate, and discriminate a variety of sensory information and use that information to plan and implement complex and novel interactions.

Ms. Smith Roley's conclusion was that claimant showed relative strengths in basic motor skills and stereognosis, and he had significant difficulty with visual perception, tactile and kinesthetic perception, vestibular and proprioceptive processing, fine and gross motor control, and motor planning. She believed these issues affected his ability to acquire skills and perform them in a smooth, coordinated manner, and would impact his performance whenever processing speed and accuracy were needed. She recommended occupational therapy of twice weekly one-hour sessions for six months plus supervision to improve sensory discrimination, reduce sensitivity to sensation, and improved fine and gross motor skills and motor planning abilities. She added that attention to his visual and language-based communications was necessary as well. She provided a lengthy list of recommended activities within the home and community.

On May 8, 2006, Ms. Smith Roley performed a re-evaluation and wrote a report. In the developmental history section of her report, she noted that the most significant area of progress is in the area of social engagement, and that currently, claimant plays with his friends, interacts with others, and fits in with his peers, to the point where other children seek him out. According to his mother, shopping events and dining out which had been a significantly challenging event now often went well. Ms. Smith Roley reported that claimant had received speech and language therapy and vision therapy once a week each and one hour a week of occupational therapy through SKY Pediatrics.

Ms. Smith Roley assessed claimant in one two-hour session and noted he had difficulty sustaining his visual and cognitive attention to task—he looked around and paused.

She indicated his processing speed was slow and there were times when he stared off and she had to wait until he reoriented to her.

On the standardized tests, she observed that some scores declined but his raw scores were stable compared to the testing a year earlier, which may have been related to the fact he was now compared to older children. She believed his profile continued to demonstrate a child exhibiting visual and somatosensory-based dyspraxia. She concluded the test results showed relative strengths in basic motor skills and significant difficulty with visual perception, tactile and kinesthetic perception, vestibular and proprioceptive processing, and fine and gross motor control and motor planning. She felt these issues affected his ability to acquire skills and perform them in a smooth, coordinated fashion, and will impact his performance whenever processing speed and accuracy are needed. She recommended continued occupational therapy for six months twice a week for an hour and a neurological examination to rule out seizure disorder, among other things.

19. Claimant was referred to SKY Pediatric Therapy for occupational therapy following Ms. Smith Roley's evaluation. Richard Furbush, an occupational therapist, wrote a progress report on May 6, 2006. He administered the PDMS-2 but could not administer it in a standardized manner as several items were repeated and the administration occurred over three sessions. Claimant's scores placed claimant well below his age and more than two standard deviations below average in grasping and fine motor quotient, and one standard deviation below average in visual motor integration. The VMI was also administered twice over two sessions separated by eight months. His score was in the average range in visual perceptual but very low in motor coordination on both tests. His overall score declined from the average range to low average.

Mr. Furbush reported claimant had shown improvement in his fine and gross motor skills but he continued to demonstrate need in both areas as well as his ability to safely participate in the demands and occupations in his daily routines. He indicated motor planning issues and visual-perceptual issues impacted his ability to judge distances, react quickly and efficiently to moving objects, and to navigate through unfamiliar environments. He believed claimant's fine motor delays impacted his self-care skills. He reported claimant had shown improvement in emotional regulation but he has become more withdrawn and shown less enthusiasm for activities. He recommended continued therapy in the areas of fine and gross motor, attention, sensory processing, and motor planning.

20. John Cone, Ph. D., has been a consulting psychologist for the service agency for 15 years, and consulted for several other regional centers. He received his Ph.D. in 1968, and has taught, conducted research especially in behavioral assessments, and written extensively. He conducted an observation of claimant in his preschool class on March 22, 2006 and in his home in March 28, 2006, and reviewed considerable amounts of information. His report of July 3, 2006 broke down the various issues, such as diagnosis and adaptive functioning, and considered all the information available on each. He summarized the historical information, current information, psychometric evidence, and clinical/qualitative evidence as they related to diagnosis, learning, receptive and expressive language, mobility, self-direction, self-care, and capacity for independent living.

Dr. Cone reported that during his preschool observation, claimant was generally appropriate as he interacted with the teacher and other students. He did not believe claimant manifested characteristics that would permit a diagnosis of autistic disorder. Claimant's teacher told him this was a typical day for claimant. Dr. Cone indicated claimant was attentive to the teacher as she read to the group and participated appropriately, raising his hand, sitting quietly and showing less random, fidgety movement than other children, and did not immediately catch on to a gluing activity, for which he needed considerable prompting.

Dr. Cone noted that claimant complied with classroom routines but needed more direction than other children at times. Claimant modulated his emotions and did not show any behavior challenges such as tantrums. He noticed claimant became distracted by his mother's presence, looking at her rather than listening to the teacher several times. He observed claimant to initiate interaction with other children, though not extensively, and on the playground, he joined in a game with other children, some children approached claimant, he made eye contact, took turns, understood his teacher's humorous remarks, smile, shared enjoyment, and had friends.

At home, Dr. Cone observed claimant working with his tutor and showed mild resistance to his mother's requests, particularly as it related to swimming. Dr. Cone felt this was within normal limits for a child his age. He noted claimant sat attentively listening to a story read by his brother's tutor, participated in a conversation about a trip to Sea World and got others to laugh when he did something funny with a pair of glasses. Overall, accord to Dr, Cone, claimant interacted appropriately with his brother and the five adults present in the home.

Dr. Cone observed that claimant walked and ran between distances at least 20 feet apart without assistance, but his gait was clumsy while running and he was slower and less vigorous than other children. When he was climbing a rope ladder, he appeared to get "stuck" halfway up and his aide helped him move along. At home, Dr. Cone observed claimant to be very well coordinated on the trampoline, and he went up and down stairs easily. He also noted claimant showed age-level feeding skills, including drinking from a glass appropriately, eating meat patties, taking off his pants and putting on his swimming trunks, and putting on socks, but he needed help with his shoes. Claimant's mother told him claimant used the toilet independently but needed help with washing, bathing, and using a tooth brush.

Dr. Cone concluded that claimant did not appear to have a diagnosis qualifying him for regional center services. He acknowledged several reports referred to claimant as being on the autistic spectrum, but he believed claimant did not meet the DSM-IV criteria for autistic disorder, nor did he meet any of the other statutory eligibility conditions.

Dr. Cone also concluded claimant did not have a disability sufficient to meet the statutory and regulatory requirements for regional center services in that claimant did not have substantial deficits in adaptive behavior related to a qualifying diagnosis. In terms of learning, he pointed out several IQ tests placed him in the normal or low normal range.

In the area of receptive and expressive language, Dr. Cone believed claimant's skills were at age level during the observations, and noted claimant did not show echolalia, pronominal misuse, or problems with register or prosody. He added claimant's imitative repertoire was well developed and he learned from others. He pointed to psychometric evidence, which in his view showed claimant scored in the average to low average range.

In terms of mobility, Dr. Cone indicated claimant walked and ran a distance of twenty feet or more without assistance, and while he seemed to run awkwardly and was reportedly delayed in gross motor skills, he was well coordinated on a trampoline. He noted claimant's test scores placed him in the average to low average range.

In the area of self-direction, Dr. Cone referred to his observations of claimant at home and at school, and test results to conclude claimant was not substantially handicapped. Similarly, in the area of self-help, he based his conclusion on his observations and test scores, although they seem to be lower than in other areas.

Dr. Cone concluded his report with a list of recommendations including involving claimant in highly structured, behaviorally-oriented experiences at home and at school, inviting claimant's parents to training classes at the regional center in positive behavior management, and so forth.

Other Documentary Evidence

21. CARD therapists created a series of goals and objectives to be reached by June 2007, with a description of his current level of functioning. The goals and objectives provided claimant would be able to:

- a. Repeat a seven to eight word novel without omitting words while maintaining appropriate speed, pitch, volume, and articulation in four out of five opportunities. He currently was able to repeat familiar four-word sentences with 90 percent accuracy;
- b. draw eight simple pictures with 80 percent accuracy. He currently was able to draw independently a circle and a square with a dot prompt;
- c. print his first and last name without transcribing/reversing letters in four out of five opportunities. He currently was able to trace his name with 60 percent accuracy;
- d. print all lower case letters in four out of five opportunities. He currently was independently able to write the letter S without prompting;
- e. use present, past, and future tense verbs correctly in his spontaneous language in four out of five opportunities. He had currently mastered 12 past irregular actions;

f. maintain attention to task for the duration of preferred and non-preferred activities 80 percent of opportunities. He currently required four adult prompts in a 20-minute circle lesson;

g. expressively identify 26 phonetic sounds in four out of five times. He currently had not mastered any phonetic sounds;

h. follow three-step related instructions from familiar adults upon first request in four out of five opportunities. He currently required prompting in 60 percent of opportunities;

i. upon initial “mand” will wait for an appropriate response from a peer or adult before repetitive “manding” in four out of five opportunities. Currently, claimant was able to wait in a structured setting without repetitive manding in 80 percent of opportunities;

j. ask appropriately for clarification or help when vague/misunderstood information or directions are given across various settings in four out of five opportunities. Currently, claimant engaged in verbal outbursts or cried if he was unable to complete an activity in about 90 percent of opportunities;

k. engage in ball play for at least five minutes with peers on the playground to include throwing, catching, and kicking a ball four out of five opportunities. He currently was able to catch, kick and throw a ball from a stationary position;

l. appropriately use negotiating skills to engage in cooperative activities with peers using persuasion, turn-taking, and assertiveness skills in four out of five opportunities. He currently took turns with peers in about 80 percent of opportunities in a structured activity; and

m. recall various information when presented with visual stimuli in four out of five opportunities. He currently was able to sustain visual attention to complete a simple game of memory match and mazes.

22. Claimant furnished a large notebook containing hundreds of documents relating to his therapy sessions with CARD for the period February 2005 to May 2006. It is impossible to summarize all the information contained in the notebook.

23. Claimant’s mother prepared a list of examples showing claimant’s functioning in each of the five areas of major life activities. In the area of self-direction and mobility, she wrote claimant at a restaurant ran into a table and “whacked” his head causing a headache that lasted a day, he loses his balance climbing down the three steps of the trampoline and falls, he loses his balance going down stairs and falls, he falls out of his chair during mealtime or when he does focused work, he climbed up a rope at school and “gazed out” for five to ten seconds, he did not stop running when ordered to stop, he and claimant’s brother

dropped to the floor and rolled on the ground in a market and would not listen to her, he forgets where he is going or to watch for cars, he hangs onto her for pressure, he has almost been hit by cars three times, and he cannot keep up with other children when playing soccer or kick the ball when it comes to him.

In the area of self-care, according to claimant's mother, he cannot brush his teeth, he can use a spoon but has difficulty with a fork or knife, he misses his mouth when using a utensil and creates a mess, he has food texture issues and only eats a few kinds of food, he can put on his clothes but in the wrong direction, he cannot button, snap, or zip his pants, and he has trouble getting his shoes on the correct feet. Claimant has trouble watering and washing his hair or putting his head under water, and hates the feel of water on his face. Claimant cannot hold a crayon for any length of time and gets very tired when trying to color or write his name, he cannot write his name and his mother is experimenting with sensory or auditory approaches rather than a visual approach to writing his name, but it took him a year to learn to write the letter S and now can write S H A pretty consistently.

In the area of learning, claimant's mother wrote it has taken claimant a year and a half to learn numbers 1 through 9 and the alphabet, and could not learn from visual cues alone but needed five different sensory books, and needs constant repetition or he will lose his skills. Claimant cannot write his name or color, he cannot maintain a tripod grip, he becomes fatigued after five minutes and wants to disengage. According to his mother, 80 percent of his peers can write their names and color for extended periods of time. She described an incident when claimant looked at a large visual array, closed his eyes, his hands went to his eyes, and he started moving his body from side to side, without responding to a question from his teacher. Claimant has trouble with visually sequencing information and he fades in and out when listening during circle time in school. He does not raise his hand to be called on but he does yell out correct answers. He does not imitate songs and hand movement to songs and has a hard time coordinating hand movements

In the area of language, claimant's mother wrote claimant cannot move his tongue correctly, he cannot lateralize his tongue or move it to the top of his mouth, he has a weak jaw, and it is therefore hard for him to articulate properly. Claimant has trouble motor planning sequencing of words, particularly words with several syllables. She wrote claimant cannot sequence three-step directions, making it hard for him to keep up at home and at school. She indicated claimant mispronounced pronouns, omitted words, and used past tense incorrectly, and he has poor articulation, making it difficult to understand him.

24. Claimant's mother went to Grace Preschool on March 22, 2006, the same day Dr. Cone did, and wrote an observation report. Claimant had a shadow aide for support. She reported claimant attempted to but was unable to do a pushup, he gazed out during circle time four times, and he did not follow directions or imitate hand movements or sing a song. He was the last one to climb a ladder and stopped in the middle to gaze out for five to ten seconds. She noticed claimant did not respond when another child called his name and the therapist had to prompt him. Claimant rode on the back of a bike with a child but could not be the driver. She observed claimant could not follow directions to perform motor activities such as coming back into a circle, lining up, jumping, and hopping.

Hearing Testimony: Regional center witnesses

25. Marilyn Thompson, claimant's service coordinator, testified she participated in the home observation on August 1, 2005. She spent about three hours observing claimant and his brother. She testified claimant was active during the visit, ran up and down stairs awkwardly, made intermittent eye contact, spoke in complete sentences, understood commands, stayed on task despite distractions, and talked to her about superheros. She saw no tantrums and there was no echolalia. His gait was awkward but he went up stairs.

Ms. Thompson observed claimant in school on March 22, 2006 with Dr. Cone. She testified claimant was indistinguishable from other children. He made eye contact and followed directions and shook his head when appropriate. He appeared to be a little slower than other children and watched them for cues. Ms. Thompson observed him make a craft project and played in the sand with other children. They talked about an imaginary dog and he enjoyed playing and talking with them. He initiated interaction with other children. There were no problems with transitions, and no aggression, scripted speech, or repetitive movements except some minimal rocking. The shadow aide told her this was a typical day.

Ms. Thompson also observed claimant at home on March 28, 2006 with Dr. Cone. She testified claimant was in a playful mood and was excited about a puppet and going to Sea World, and shared it with his mother and therapist. His conversation was reciprocal. He was compliant with the therapist. He briefly cried and whined when he had to go swimming, but he dressed himself. She felt his communication was within normal limits.

26. Arlene Downing, M.D. is the director of the health resources group for the service agency, a team consisting of nurses, doctors, psychologists, and others who work together on issues involving eligibility and training. She has worked for the service agency for twenty years and has considerable experience determining eligibility. She reviewed claimant's request for services and the information available, and concluded on September 30, 2005 that claimant was not eligible for regional center because he did not have a substantial disability.

In reviewing the records, Dr. Downing was looking for a description of claimant's development—what he could do—related to age expectations, medical workups, diagnoses, and recommendations. She noted from Dr. Donnelly's November 25, 2002 report that claimant was the product of a high-risk pregnancy, was premature, and experienced problems early in his development; he felt the risk factors placed him at higher risk for future difficulties and that more intervention would be needed; but nevertheless, Dr. Donnelly did not believe he was autistic and gave him a CARS score of 21, well below the autism cutoff of 30. In Dr. Lott's February 21, 2003 report, when claimant was 22 months, Dr. Downing pointed out the doctor did not use any diagnostic tools and relied on his parents' report and his observations to make an "initial" diagnosis of autism.

Dr. Downing reviewed Dr. Donnelly's report of June 3, 2003 in which he reported claimant had made gains overall but his receptive and expressive language skills were

delayed. In Dr. Downing's opinion, however, a delay with a premature child is not normally used in assessing the length of the delay, and the amount of delay only related to the decision that claimant needed some intervention. Dr. Donnelly again indicated claimant did not meet the DSM-IV criteria for autism. Dr. Downing noted that in Dr. Donnelly's November 4, 2003 report, he had reviewed various reports including Dr. Lott's report containing a diagnosis of autism, but he still believed claimant did not meet the DSM-IV criteria for autism, although he felt the possibility of mild autism had to be monitored.

Dr. Donnelly's June 8, 2005 report considered Dr. Bostani's report and found claimant did meet DSM-IV criteria for mild autism spectrum disorder. Dr. Downing pointed out Dr. Donnelly did not indicate what criteria claimant met and furthermore, there was no DSM-IV diagnosis of autism spectrum disorder.

Dr. Downing reviewed the EEG report, Dr. Donnelly's September 6, 2006 report, and other information relating to claimant's staring spells, and in her opinion, there was no evidence claimant suffered from a seizure disorder.

27. Mary Parpal, Ph.D., is a psychologist with the service agency whose duties include reviewing eligibility. She reviews about 25 to 50 applications for services a week. Previously, she performed assessments. She reviewed claimant's application for eligibility on September 27, 2005, beginning with the early start records, and concluded that despite his diagnosis of mild autism, claimant did not demonstrate substantial disabilities in three or more of the requisite areas and that his problems were not expected to last indefinitely.

Dr. Parpal pointed to a number of reports to substantiate her conclusion. She found evidence in Dr. Donnelly's reports that claimant played imaginative games with others, he had no stereotypical behaviors, and no characteristics that indicated he was on the autism spectrum. She noted that Dr. Donnelly found claimant had made gains in language, was interactive, and there was no loss of acquired skills. She pointed out in Dr. Lott's report, he found evidence of good eye contact, self-direction, and his description of his behavior was that of a typical 22-month-old. Based on that, she believed his diagnosis of autism was only an "initial" one.

In one Rainbow Kids report, Dr. Parpal found information that claimant had made tremendous progress in make-believe activity, had improved in language, and he was ambulatory although his mobility was delayed. She noted strengths reflected in a CARD report of January 29, 2004 of language, the ability to follow commands, his ability to point to things he wanted, the use of words and phrases and normal intonation, his ability to use a spoon and fork and straw and drink from a cup, his ability to bathe himself, and his playing with other people and toys. She felt his self-help skills were "on track" and his play skills were "age-appropriate." In another Rainbow Kids report when claimant turned three, she believed evidence suggested claimant was doing well and based on that report, it was determined claimant was not then eligible for regional center services. She believed his language was average, his social-emotional level was at or near age level, he showed independence, there was social reciprocity, and he initiated play with minimal adult supervision. She believed this information did not disclose any substantial disability in self-

direction but showed some delay in self-help. In another report written at age three from the District, Dr. Parpal noted that claimant separated from his brother, went with the examiner, asked for a break if he wanted one, responded to direction, and his play and pretend-play skills were appropriate. She noted the Bayleys test was normal, his motor skills were delayed but within normal limits, and the ADOS showed autism spectrum disorder but not autism. In addition, she found improvement in that some echolalia had been reported in the past was not then present. She found some discrepancies between parent reports and standardized testing. Based on its testing, the District made claimant eligible as speech and language impaired, not because he was autistic. She noted a decision by a school district to make a student eligible for special education services has a lower standard than a regional center determination of eligibility.

Dr. Parpal interpreted Ms Hein's report of June 10, 2004 as showing his receptive speech was low normal and his expressive language was normal. She indicated there was no evidence of atypical behaviors of autism reported.

In Dr. Bostani's 2004 report, Dr. Parpal pointed out that claimant took the WPPSI-R, which she described as a difficult test to administer to children, and few are given it, because it requires self-control, the ability to follow directions, and the ability to sit long enough to complete it. She testified claimant's IQ was in the normal range. On the Leiter-R, she indicated claimant's scores were normal, and on the Vineland, his communication skills were normal and his daily living skills, socialization, and motor skills were borderline. She felt the CARS, if it placed him on the autistic spectrum at all, put him at the mild level.

In Dr. Dores' report, Dr. Parpal found no disruptive behavior, he transitioned well, his unstructured play was fine, and he was happy and engaged in recess. Claimant's teacher reported no behavior excesses as well. She indicated Dr. Dores concluded there was mild noncompliant behavior based on parent report and he felt parent training was necessary. Based on Dr. Dores' indication that there were no problems with transitions, Dr. Parpal disagreed with Dr. Donnelly's observation in his June 8, 2005 report that there were severe problems with transitions. Further, in that report, Dr. Parpal pointed out Dr. Donnelly did not specify which DSM-IV criteria of autism claimant met, although she noted information about eye contact, repetitive behavior, and prosody of language in the report.

Dr. Parpal reviewed various occupational therapy reports and found nothing to suggest claimant was substantially disabled. At most, they showed he was clumsy and might have visual problems. Dr. Parpal reviewed Ms. Hein's March 10, 2006 report and found no substantial disability in language but rather that claimant scored within normal limits. She acknowledged that there were some impairments in specific areas but stressed the overall findings were normal.

Dr. Parpal also reviewed Dr. Bostani's second report of May 2006. She noted claimant improved his IQ scores, which were in the average range, as was his pragmatic language. She found no evidence of a substantial disability on the Vineland, believing that his living skills were borderline and his socialization was adequate. Dr. Parpal commented that Dr. Bostani's observation showed claimant interacted verbally with other children, he

imitated play, and appeared to be a boy doing all right. She testified that while claimant was distracted at times, the other children were also distracted. She pointed out the teacher said claimant's play and socialization had improved, and he was mindful of others and thoughtful. Based on this, Dr. Parpal found no evidence of significant deficits.

Dr. Parpal reviewed IEP notes from June 2006 and reported that they suggested claimant had more behavior problems at home than he did at school. She testified the District performed cognitive testing and the KABC-II placed claimant in the average range, as did the Woodcock-Johnson, except for spelling, which she thought might have suggested a learning disability. She noted the CDI rating showed a significant delay but it was not consistent with other reports or objective tests. As an example, she pointed to information that claimant walked and ran, climbed a cargo net and stairs, wrestled, and did a flip, and this information was different from reports from his mother. She noted other discrepancies between claimant's mother's reports, and CARD information in the areas of feeding, dressing, and toilet training as well as teacher reports. Dr. Parpal reviewed the school observation report and noted claimant participated and interacted and laughed with others, had had delays in responding and needing prompts to answer questions. Nevertheless, she believed this information showed he was more independent at school than at home. As far as speech and language was concerned, she found evidence that he scored in the average range and that the objective testing performed by the school contrasted with parent reports. She testified the occupational testing showed claimant could take off his shoes and socks independently, use utensils, wash and dry his hands, and button, zip, and snap with a dressing cue.

Dr. Parpal also reviewed CARD IEP recommendations contained in a June 1, 2006 report, and found there were low rates of noncompliance and tantrumming, and nothing unusual compared to other five-year old children. She noted the aide reported claimant had friends, was more assertive and independent at school than at home, and could address problems and his emotions at school. She also noted claimant could drink from a cup, but needed help with dressing and using the toilet, but it was not unusual for children to need help.

Dr. Parpal reviewed the reports of Dr. Ito and Dr. Cone and found no evidence of substantial disability. She agreed with their reports.

28. Dr. Cone testified he became involved in claimant's case after his parents re-applied for regional center services, the service agency denied the application, and his parents appealed the decision. He did not participate in the original decision, which found claimant was not eligible for regional center services. He was asked to review claimant's records to determine the level of his adaptive functioning, and not to make an independent diagnosis. He reviewed records and performed multiple direct observations. His testimony reiterated the opinions he set forth in his report. Dr. Cone testified he did not address the issue of a diagnosis.

The structure of Dr. Cone's testimony was similar to his report. He reviewed all the evidence available in each of the five major life areas as required by the Lanterman Act.

Regarding learning, Dr. Cone noted that claimant's test scores typically were lower when he was younger, but they improved over time, and he was currently age typical. He pointed out that claimant was born prematurely, and there was some catching up, and in addition, he had received very good services. He testified he observed claimant in class and that claimant was appropriate as a learner, but had some problems with fine motor skills. He felt claimant was an underachiever but not substantially so.

Regarding language, Dr. Cone believed claimant was at age level. He found no evidence of autism, and testified the test showed his ability increased. He pointed out there was a wide discrepancy on the ABAS between reports from claimant's mother and teacher. He noted the CASL was within normal limits as was the PLAI-2. Based on his observation of claimant, he did not agree with claimant's mother that his social function was that of a two-year-old. He testified he did not have trouble hearing claimant and while he did mumble or was inarticulate at times, it was no different from a typical five-year old. He reiterated the testing showed no substantial disability.

In the area of mobility, Dr. Cone agreed with Dr. Parpal that not much was required of a consumer in order to determine if he or she were mobile. In essence, it is the service agency's position that if a person can move from one point to another without assistance, then he or she is not eligible for regional center services. Dr. Cone observed claimant walk without assistance, and run awkwardly. Claimant also could play on a trampoline. Dr. Cone did not believe that claimant's daily functioning was handicapped.

Dr. Cone reviewed claimant's records in the areas of self-direction and self-care with an eye toward determining if there was appropriate development. He testified claimant knew what was appropriate in social situations and had common sense. He found that while claimant did not wait his turn, this was not atypical. He found claimant could modulate his emotions and this was important, he could interact with other children, and the tests had a wide range, with teacher reports much higher than parent reports. Dr. Cone's general impression was that claimant functioned within normal limits.

In the area of self-help, Dr. Cone testified he did not have much of an opportunity to observe claimant's abilities at home or at school. He felt based on the information he had reviewed that this was claimant's lowest area but even that was within normal limits if data from claimant's parents were not used. He observed no aggression or self-stimulatory behavior, and noted that claimant's mother was adept at handling claimant's whining.

Dr. Cone reviewed Dr. Bostani's 2006 report and testified his impressions were not changed by the new information contained in it. He noted the test result on the WPPSI-III was average, and there was little difference between the verbal and the performance portions, or in the subtests. He testified that children with autism have discrepancies, the verbal was usually lower than performance, and there was some scatter. He noted Dr. Bostani administered an abbreviated version of the Leiter-R and the results were unchanged and in the average range. He pointed out claimant's scores on the BRIEF-R, which were not within normal limits, did not correlate with his IQ scores. He again noted that the scores on the Vineland and BRIEF-P were based on parent report.

Dr. Cone examined data produced by CARD and observed that the goals and objectives were heavily academic. He looked for challenging behavior and found some were listed and tracked initially, but they no longer were tracked, which suggested to him that the behaviors were no longer addressed. He noted the information contained in the data differed from the information provided by claimant's parents.

In Dr. Cone's report, he created two graphs of each of claimant's scores in the five major life areas. For the period from October 2002 to mid-2006, he found that the mean score in learning, mobility and self-direction was in the low 80s, and language and self-care were slightly below 80. One standard deviation in a standard score is a score of 85, and two standard deviations is 70. In Dr. Cone's view, a standard score of two or more standard deviations below the mean indicated a substantial disability. Dr. Cone's graph also showed some of claimant's highest scores in every area but self-care was close to average, or age typical. For the period from March to June 2006, Dr. Cone found that claimant's test scores on the ABAS-II and Vineland averaged in the low 80s. This graph showed how differently claimant's mother and teacher rated claimant's abilities.

Dr. Cone reviewed Ms. Smith-Roley's report and noted that there was little progress in sensory integration. In his opinion, sensory integration does not have empirical support and the therapies based on sensory integration have no support.

Hearing testimony: claimant's witnesses

29. Susanne Smith Roley testified she is a licensed occupational therapist and specializes in children with learning behavior issues. She performed two evaluations of claimant. She did not provide any therapy. She reiterated the findings she documented in her reports. After evaluating him twice, she found that there was a vulnerability in his family. She believed his gross motor scores showed his deficits to be severe. In her opinion, a standard deviation of more than one was significant.

In Ms. Smith Roley's opinion, claimant had more difficulty in the second testing, and overall, his growth in the year between testing was not a typical year's growth. His scores were mostly lower and rarely in the typical range. She noted he fell a lot and had some spatial errors. She felt he had praxis dysfunction and she was surprised he had not improved. She testified claimant's processing was slow and irregular, and it was hard to keep his attention. She noted there were times when he went blank and she had to repeat her instructions. She believed claimant was significantly delayed in balance, and the great amount of trouble he had with his body and fine motor movements impacted his ability to perform complicated task, such as activities of daily living. In her opinion, the long time it took claimant to perform tests showed how his ability to learn was negatively impacted.

30. Joanne Hein is a speech and language pathologist in private practice for the last twenty years. She obtained her masters degree in 1976 and has worked with autistic children since then.

Ms. Hein's testimony was inconsistent with her reports and is given little weight. Her reports provide a balanced evaluation of claimant's strengths and weaknesses. Her testimony, however, obscured his strengths and sought to portray him as substantially disabled. She emphasized low scores and criterion scores, which had only cutoffs, and were not standardized, and disregarded higher scores, particularly those she had emphasized in her reports.

31. Beth Ballinger is an optometrist who specializes in visual functioning for children with developmental disabilities. Her testimony mirrored her report. She has seen claimant about 25 times. In her opinion, claimant has global motor difficulties, which negatively impacted his ability to perform many tasks, such as performing daily living skills or learning to write. She explained that his poor motor coordination affected his vision because he has problems focusing and getting details and performing tasks for extended periods of time. When claimant got tired and overwhelmed, he tended to turn his eye and then runs into things and loses his sense of where he is. She added that he could not differentiate depth and has double vision, he did not know left from right and therefore did not know which hand to use to hold a pencil. When he held a pencil, according to Dr. Ballinger, claimant's grip showed he did not have finger fluency, and he moved with his shoulders instead of his hands and fingers. She testified that claimant could write three letters, which at his age was not enough.

Dr. Ballinger testified claimant's deficits in vision and other areas also indicated a hearing impairment, and all his deficits combined to negatively affect his ability to learn language. He had deficits in visual acquisition, that is, gathering information, and he could not maintain visual contact with a target. She believed this affected his ability to learn to read. She felt all of claimant's visual abilities were fragile and could fall apart. She testified he has learned to touch an object to corroborate what he saw, and had great difficulty with visual discrimination. His difficulties, she believed, showed that despite his high potential, claimant could not do what he had the ability and intelligence to do.

As an example, Dr. Ballinger believed that claimant's poor visual memory caused him not to be able to recall letters and numbers. He was unable to interweave input from his different senses and therefore look and listen at the same time, or look away and remember what he had just seen. This caused him to have difficulty recognizing letters, or to differentiate the same number but in a different context. He also had difficulty recalling the sequence of numbers or letters, which made it difficult for him to learn the alphabet.

Dr. Ballinger noticed that claimant often turned his head or closed his eyes or squinted, and this had the effect of causing him to lose depth perception and make it difficult for him to locate where objects are, and this created a safety hazard. She thought claimant might not see a car or crash into things, or not look up and down a street before crossing.

Dr. Ballinger observed that claimant engaged in parallel play but would not interact with others, and he was shy. She felt he had difficulty with many self-help tasks such as buttoning or eating, and he tended to put his shoes on the wrong foot. She testified that self-dressing was a reflection of making discriminations, and claimant had deficits in this area.

She noted he answered questions with one-word answers if he answered at all, and tended to nod and shrug. She felt his communication was poor and he did not use language. Dr. Ballinger did not believe claimant could multi-task such as drawing and looking at an object, or looking at other children reading gestures. She described the type of therapy she used with claimant and termed his progress “slow.”

32. Mitchel Perlman, Ph.D., is a clinical psychologist and maintains a private practice specializing in assessments in the areas of special education including autism, probation, and child custody, with some therapy. He has been licensed for twenty years and considers himself a neuro-psychologist. He received extensive training and cross-training in psycho-educational assessments. He received some training in ABA therapy for children with autism but does not provide therapy to such patients. He has never worked for a regional center or performed an evaluation for a regional center, but he has attended IEP meetings. He reviewed claimant’s records and testified in order to clarify data relating to test scores. He did not make a diagnosis of claimant and did not assess him.

In order to illustrate his evaluation of the reports generated by the numerous professionals who had assessed claimant over the years, Dr. Perlman created a chart, which listed the result of each assessment as it related to the five major life areas: self-care, receptive and expressive language, learning, mobility, and self-direction. He concluded claimant had substantial disabilities in each of the areas based upon his review of the standardized tests and the comments made by evaluators in their reports. In several areas, some scores from one test would show a substantial disability while other scores would not show a substantial disability, and when that occurred, Dr. Perlman used his judgment to reach his conclusion. He testified that while some test results were high, claimant’s pragmatic application of the tested skill was low.

In the area of language, Dr. Perlman pointed to Dr. Bostani’s finding that claimant’s processing speed was slow and that despite his intelligence, claimant had to use it in a circuitous route, and claimant’s executive functioning was deficient. He testified that when executive functioning went awry as it did with claimant, learning was disrupted. Dr. Perlman pointed to claimant’s high scores on the BRIEF-R which corroborated that. He found claimant’s problems were related to attention, which affected his ability to input information and retrieve stored information. He testified there is little correlation between IQ scores and adaptive functioning, and that claimant’s average IQ scores did not reflect claimant’s difficulties in adaptive functioning. In his chart, Dr. Perlman pointed to Ms. Smith Roley’s report of visually related and tactile difficulties, Dr. Ballinger’s report that showed claimant’s poor performance on six of seven subtests of the TVPS, claimant’s poor performance on the block design and BRIEF-R administered by Dr. Bostani, claimant’s performance on the District’s tests (CDI, TAPS-R, Woodcock-Johnson test of spelling, pragmatic language, pre-academic skills, and fine motor skills), and Dr. Ito’s ABAS-II.

In the area of language, Dr. Perlman found claimant had functional limitations with articulation and communication. He testified the ABAS-II score of 70 administered by Dr. Ito showed the difference between IQ and the ability to communicate. He also pointed to Ms. Smith Roley’s finding that claimant had poor receptive language for sequential tasks, the

CELF-P2 problems found by Ms. Hein, and the SIB-R, CDI, and ALPHA tests administered by the District.

In the area of mobility, Dr. Perlman testified claimant has difficulty with motor control and his scores were weak in many areas. He felt there had to be a behavioral manifestation of those numbers. He pointed to the VMI administered by Dr. Ito of 59 which he felt showed claimant was unable to draw anything. He also noted the SIB-R and CDI scores on tests administered by the District, the VABS-2 administered by Dr. Bostani, and Ms. Smith Roley's findings for poor fine and gross motor skills.

In the area of self-care, Dr. Perlman testified that all the scores had consistently showed claimant was substantially disabled. He pointed to such scores as the VABS, Daily Living administered by Dr. Bostani, the CDI and SIB-R administered by the District in 2006, and the ABAS-II administered by Dr. Ito.

Dr. Perlman testified that in the area of self-direction, claimant's scores were low.

Dr. Perlman was aware claimant was receiving services from a number of sources. He testified that when services stopped, children with autism often regressed. In his experience, services have to be intensive in order to get some movement, and they have to be pertinent.

33. Claimant's mother testified at length and described the level of claimant's functioning. Claimant and his identical twin brother were both born prematurely. She has an older son who has been diagnosed with autism and there is an uncle in the family who also suffers from autism. She testified that after she brought claimant home from the hospital, he screamed for 18 hours a day for three months, until he finally calmed down at age six months. When he had not started walking by 15 months, was not speaking, and was not making good eye contact, claimant's mother became concerned and contacted the service agency. Claimant then began receiving Early Start services including speech and physical therapy from Rainbow Kids. During this time, she felt claimant was very delayed in the area of language. In February 2003, she had claimant evaluated by Dr. Lott who diagnosed autism.

In January 2004, before claimant turned three, his mother received some training from the service agency, and in March 2004, she asked the service agency for services. She testified the service agency determined claimant was not suffering from autism, and denied eligibility. However, she contacted the District which found delays but not autism, and it provided speech and occupational therapy. She then had claimant evaluated by Ms. Hein, who advised her that claimant's receptive language was not where it should be and he had horrible eye contact. In addition, claimant, according to his mother, did not hear and see well, and this affected his functioning. He also had a difficult time articulating his speech, and he often omitted words or syllables. She then took claimant to Dr. Bostani who diagnosed autism, and she was horrified at his low IQ and achievement scores.

Claimant's mother decided to pull claimant out of school and begin therapy with CARD. At that time, claimant omitted pronouns and other words, his prepositions were not right, and he slurred and mispronounced words. One goal of CARD was to increase sentence length and correct his use of pronouns. She started speech therapy as well. She testified that claimant had potential but his functioning did not reach his potential. As an example, she testified that during therapy with CARD, claimant could brush his teeth, but he could not do that at home. The same was true for potty training. She believed claimant could not generalize and pointed to his Vineland test score as evidence.

In addition to CARD and speech and occupational therapy, claimant's mother had claimant evaluated by Ms. Smith Roley to try to understand claimant's "gaps." The findings were significant, showing substantial handicaps in such things as holding a pencil or maintaining his balance. Claimant's mother testified claimant often falls out of a chair, and puts his hand over his eye when he has trouble tracking an object. She attributed claimant's inability to write his name to his visual problems. She added that his proprioceptive ability was out of kilter, and that was why he was given a trampoline, which has proved helpful.

Claimant's mother described an observation she made at school. The teacher told the students to go to a station, but claimant did not know where to go and stood still. The teacher repeated the instruction to him, but his mother had to help him. She testified claimant was the only child in the class not to know where to go. According to his mother, claimant does not process language well—he will not respond to his name and does not understand directions. She was very concerned about his habit of "gazing out" and losing connection with his environment.

Claimant's mother organized her testimony around the five major life areas to show that his functioning was substantially disabled. She prepared a chart and list of examples. She indicated he did not play well with other children, usually just engaging in parallel play without reciprocal language. When he had an aide, however, claimant did better, but he does not now have an aide, and he has regressed. Claimant does not have any friends except his brother. She described an incident in which claimant was in the middle of climbing a ladder while playing firefighter, and he just stopped and did not chase the other children like he was supposed to do. She was concerned that the same could occur while he was crossing a street. Another example occurred when claimant lost his balance while at a carnival at school, he tripped, and fell on his face, and he did not put out his hands to break the fall. She added that claimant continually lost his balance and falls all the time. In fact, when Dr. Ito came to their house, claimant fell off the trampoline. He falls off chairs. She testified Ms. Smith Roley's findings confirmed his motor issues. She added that claimant had oral motor issues in that he cannot move his mouth correctly, and has received programming to address that.

Claimant's mother fears that despite all the services she and her husband have provided for claimant, including CARD, vision, and occupational therapy, there are still many gaps, and if he stops receiving services, he will be a mess. She believed claimant could get better, and noted some of his scores were improving.

According to claimant's mother, there are many examples of claimant's behavior to show he is autistic. She indicated his language was delayed, his social language was not normal, he did not play cooperatively but in a parallel way, he never raised his hand in class, he does not appreciate subtle cues, he does not answer questions, he has horrible eye contact and will look to the side because eye contact is stressful, and he cannot generalize. In addition, he has oral motor issues, articulation issues, and motor apraxia. She testified everything with claimant was heightened, including many sensory activities like washing his hair (he screams) and brushing his teeth. She indicated claimant was a very picky eater, makes a mess when he eats, and has many noncompliant behaviors. His tantrums started when he was two years old, and included screaming and resistance to getting dressed, thereby causing his mother to routinely bring him to school late. She estimated he has three tantrums a day, each lasting ten to thirty minutes. She handles this by placing him in time out, but she reported he did better during therapy than with her. In her view, claimant cannot "self calm" or know how to get attention appropriately. Another problem claimant's mother reported was "darting." In one example, claimant and his brother were in a grocery store when they both took off running out the store and did not stop despite many calls. Claimant's mother had to chase them, and after she caught them and brought them back into the store, and while she was in line to pay for her groceries, the boys dropped to the floor, rolled around, and hugged each other. On another occasion, while in church, claimant and his brother ran through a parking lot, not stopping when called, and were almost hit by a car.

Claimant's mother testified claimant was not coordinated enough to kick a soccer ball, although he plays on a soccer team. She did not believe he could handle the visual array or imitate motor movements necessary to kick a ball. In addition, she noted claimant could not perform two physical tasks at the same time such as sing a song and move his hands. She felt his motor planning was poor. When claimant is climbing stairs, he does all right as long as he holds onto the rail, but he does lose his balance. She noted losing his balance in other situations occurred most often when claimant was concentrating intensely on something else, such as when he was eating or writing, and as a result, he would fall out of a chair and injure himself. She testified claimant fell about twice a day, and screamed and overreacted.

In the area of language, claimant's mother testified that claimant often pronounces words incorrectly, and when he does so, she pulls out his tongue to help him feel where his tongue should be in order to make the correct sound. She testified he needed speech therapy, but the family was unable to afford it, and she stopped it about a year ago, but CARD is working on speech. She noted claimant did not speak in whole sentences and often left words out. He also misused tenses and pronouns, and spoke of himself in the third person. She felt claimant did not generalize pragmatic language and his teachers saw it as well as she did. As a result of his poor speech, claimant did not have any friends and did not play with other children, other than during organized play dates. She found claimant could not generalize play from the play dates, such as sharing, to unstructured play. She testified that other children noticed how poorly claimant spoke and would look at him funny or ask her to translate what he had said. She testified claimant's teachers had mentioned this to her and was concerned about it.

In terms of receptive speech, claimant's mother testified it was hard for claimant to understand subtle cues from others. For example, he did not get jokes. He did not play cooperatively with other children and did not talk to them except one child who had come to his house. Because of his deficits, claimant's mother decided to enroll claimant in junior kindergarten.

In the area of self-care, claimant's mother testified dressing was still a problem although he had made some progress. She described his ability to put on his shirt and underwear but he could not button or snap or zip or ties his shoes. She indicated claimant could perform some of these tasks with hand over hand prompts, but he did not do them by himself. When he put on clothes, he typically but them on backwards and his mother had to prompt him to put them on correctly. When he opens a drawer to get out clothes, the drawer falls out. When claimant eats, he usually makes a mess by putting food partially in his mouth and the rest falling on his clothes. According to his mother, claimant does not use a knife, and when he gets a glass of water, typically spills some as he is filling the glass. She testified claimant hated the feel of water and other sensory inputs. After using a toilet, claimant had difficulty wiping his bottom, although when he is in therapy, he does so correctly. She worries about his toilet training abilities when he is in school.

Claimant's mother testified claimant generally had a difficult time with fine motor tasks. For example, his handwriting is virtually nonexistent, and despite working with him for more than a year, claimant could not write his whole name. Claimant's mother discovered that claimant learned his letters better when he could feel them, and is pursuing a sensory form of learning. She does not believe he has anywhere near the writing ability of a typical five-year-old child.

Claimant's mother described claimant's typical day. He was in school for three hours, but without an aide because the family did not have the funds to hire one. She would like to see him with an aide. Claimant receives three hours of CARD therapy a day as well, with one hour a week devoted to occupational therapy and another hour a week to vision therapy. She noticed that claimant becomes fatigued after a long day and therapists had to work harder with him when he was tired.

In the area of learning, claimant's mother testified it took claimant two years to learn numbers because of his visual input problems, and things only improved after a sensory approach was implemented. Because claimant has to concentrate so hard to learn, he fatigues easily and then becomes frustrated and he stops. He also loses his attention and fades out. She testified his working memory is poor and is a subject his teachers have worked on. She testified that claimant could not sequence three directions and imitate, so learning was difficult. She discovered that there were ten things children needed to know before they entered kindergarten, and she believed claimant could do four them: state his full name, know his phone number, know his birthday, and recognize and name the four basic shapes. She did not believe claimant could recognize and print his first name using capital and small letters, know traditional nursery rhymes, recognize and count one through ten out of sequence, count to 30, recognize upper case letters of the alphabet and lower case letters

of the child's name, and locate the front and back of a book, point to a letter and a word, know where to start reading on a page, and understand reading is from left to right.

According to claimant's mother, the family has provided 1,500 hours of therapy through CARD, plus aides, and speech, occupational, and vision therapy in the last two years.

LEGAL CONCLUSIONS

1. Under the Lanterman Act (Welf. & Inst. Code §§ 4500 *et seq.*), the State of California accepts responsibility for persons with developmental disabilities and pays for the majority of the "treatment and habilitation services and supports" in order to enable such persons to live in the least restrictive environment possible (§ 4502, subd. (a)). The State agency charged with implementing the Lanterman Act, the Department of Developmental Services (DDS) is authorized to contract with regional centers to provide developmentally disabled individuals with access to the services and supports best suited to them throughout their lifetime (§ 4520).

2. Welfare and Institutions Code section 4512 provides in part:

(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

...

(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) *Capacity for independent living.*

(7) *Economic self-sufficiency.*

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

3. California Code of Regulations, title 17, section 54000, provides in part:

(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

4. California Code of Regulations, title 17, section 54001 provides

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Receptive and expressive language;

(B) Learning;

(C) Self-care;

(D) Mobility;

(E) Self-direction;

(F) Capacity for independent living;

(G) Economic self-sufficiency.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

5. The voluminous record in this case contains numerous test results. Many of those tests are standardized tests. A dispute arose among the experts as to how the results should be viewed in terms of determining whether the score indicated a substantial disability. According to Dr. Cone, a score that was two or more standard deviations below average was necessary in order to find a substantial disability for the particular skill tested. Thus, on a test with a score of 100 indicating 50 percent of the population was above and 50 percent below, and one standard deviation consisting of 15 points, Dr. Cone believed only a score of

70 or below showed a substantial disability. Ms. Smith Roley testified one standard deviation or more showed a substantial disability. Dr. Perlman drew his line somewhere between the two but could not give a precise number. He testified that the range between 90 and 110 was average, but argued that to require a score of 70 or below was too limiting and would exclude 98 to 99 percent of the population from receiving regional center services.

It is common for psychologists to take into account variations in testing. For example, a score of 70 or below in a standardized IQ test generally is considered the threshold for finding mental retardation. However, Dr. Perlman testified a score of 75 could show mental retardation as well. Given testing differences and variations, that is a reasonable conclusion.

For purposes of determining substantial disability, where no numerical dividing line exists, consideration of testing variations and differences is helpful when considering a score between one and two standard deviations from the norm, that is, a score between 70 and 85. Using the five points Dr. Perlman used, it can be determined that a score of 75 or below would suggest a substantial disability, while a score of 80 and above would suggest that there was no substantial disability shown by that test. Accordingly, scores between 75 and 80 present the most difficulty in deciding whether the test points to substantial disability or not.

6. A preliminary matter arose as to whether the vision problems found by Dr. Ballinger could be considered in determining whether claimant is substantially disabled in three or more of the listed major life activities. Claimant's visual problems cannot be considered a symptom of autism and would not be addressed by regional center services. It would be logical to conclude that claimant's visual problems should not be considered in deciding whether he is substantially disabled. However, sections 4512 and 54001 of the Regulations contain no language to suggest a functional limitation has to be related to or constitute a symptom of the underlying developmental disability. The statute and regulation only require significant functional limitations in three or more of the listed major life activities. Thus, it must be concluded that a qualifying diagnosis coupled with evidence of any type of significant functional limitation is sufficient to find eligibility.

7. The issue in this case centers on one of the requirements set forth in section 4512 that must be met before claimant can be found to be suffering from a developmental disability and therefore eligible for services from the service agency—the disability must be substantial. The service agency does not contest the autism diagnosis. Accordingly, claimant must establish his disability is substantial and it can be expected to continue indefinitely in order for him to receive services under the Lanterman Act.

After all the reports and the testimony of all the witnesses have been considered, the conclusion is inescapable that the issue is one of degree. The service agency's experts believe claimant suffers from some disability, but not a substantial one, while claimant's experts believe the disability is substantial. Finally, claimant's experts concede claimant has made some progress over the years but that the disability will last indefinitely while the service agency's experts believe the progress he has made show his disability will not last indefinitely. One side points to all the things claimant can do; the other side points to the

things he cannot do, or cannot do well. A review of all the evidence shows this is a very close and difficult case.

In reviewing the testimony and the reports of the various experts, due consideration is given to the training, background and experience of each in their respective fields. It must be noted that none of claimant's expert witnesses have had any significant experience dealing with eligibility of applicants for regional center services. On the hand, Dr. Cone and Dr. Parpal have worked for or consulted with regional centers for years and routinely consider whether applicants for regional center services meet the statutory criteria.

In addition, more consideration is given to later testing than to earlier testing.

When the Legislature amended section 4512 in 2003 to add subdivision (l), it greatly increased the level of disability a consumer must show before he or she can receive services from a regional center. In addition, the definition of substantial disability contained in section 54001 contains two parts: it requires a condition which results in major impairment of cognitive and/or social functioning, and the existence of significant functional limitations in three of the seven listed areas. To decide these issues, the evidence on each of the five major life activities relevant to this case must be considered separately:

a. Receptive and expressive language. A number of tests suggest claimant is not substantially disabled in this area, while a few suggest he is. Dr. Ito administered the Stanford-Binet test and claimant achieved a score of 98 on the verbal test. Dr. Bostani administered the WPPSI-III in 2006 and claimant achieved a verbal score of 104, with scores on the four subtests ranging from average to above average, while his processing speed was low. His score on the TOPL of 86 was below average, while his scores on the VABS-2 were generally adequate to moderately low, with receptive and expressive communication average and coping skills moderately low. His score on communication was 87 and socialization was 86. The District administered the PLAI-2 and claimant scored in the average range, as was his score on the CASL. He was in the delayed range in the Assessment of Phonological Processes-Revised but on the CELF-PS2, a checklist completed by claimant's mother, his score was well below the criterion for his age. Similarly, the CDI and SIB-R based on information from claimant's mother placed claimant's development as substantially disabled. However, on the SIB-R reported by claimant's preschool teacher, claimant's score was average age-appropriate.

Ms. Hein's scores require some analysis. On the CELF-P she administered in 2004 when claimant was three years old, claimant's language score was 79 and his age equivalent was two years and seven months years. The results of the same test administered in 2006 showed significant improvement, with claimant receptive language composite at 88, his expressive language composite at 100, his language content composite at 95, his core language composite at 96, and his language structure composite at 94. Ms. Hein's testimony that the criterion cutoff subtests, which show claimant does not meet age criteria and detract from the significance of the standard scores, is rejected. More weight should be given to the standard scores than the criterion scores.

On balance, the weight of the psychometric testing, particularly the objective, standardized testing, does not show claimant is significantly functionally limited in the area of language. At most, the testing established mild delays in language.

Evidence describing claimant's abilities in language that are not based on testing is varied. Claimant's mother paints a bleak picture of claimant's abilities. On the other hand, Dr. Cone reported from his observation of claimant at home and at school that claimant generally interacted appropriately with peers, his teacher, and other adults. Ms. Thompson's observation did not reveal any significant disabilities in language. Dr. Bostani observed claimant at school and at home. Her observations did not reveal a substantial disability in language. However, Dr. Ballinger's description of claimant's language abilities showed a significant disability in language. Dr. Donnelly's reports, particularly his latest one in 2006, showed claimant had weaknesses. In light of his view of claimant's autistic spectrum disorder as mild, his reports of weaknesses cannot be construed to indicate a belief on his part that claimant's abilities are significantly disabled.

Based on all of the evidence relating to claimant's expressive and receptive language, and in particular objective test results and the testimony and opinions of Dr. Cone and Dr. Parpal, it must be concluded that the evidence did not establish a significant functional limitation in claimant's receptive and expressive language.

b. Learning. Claimant's IQ as measured by the WPPSI-R by Dr. Bostani and the Stanford-Binet by Dr. Ito were average. His score on the Bayley Scales of Infant Development-II administered by the District when he was three years of age was within normal limits as were the KABC-II, TAPS-R, and Woodcock-Johnson Test of Achievement administered by the District in 2006. His scores on the Leiter-R administered by Dr. Bostani in 2004 and 2006 were average except for forward memory which was low. His score on the ABAS-II administered by Dr. Ito was 75. On balance, these scores clearly show claimant has the potential to perform at age appropriate levels.

However, Dr. Ito also considered the ABAS-II completed by claimant's mother that placed claimant in the mildly to moderately delayed ranges. She interpreted the VMI as showing possible weakness. She recognized his cognitive strength and could not say if his delays in current functioning were suggestive of a life long disability. A review of her entire report leaves the impression that while she found delays and weakness that required intervention, none reached the level of a significant functional limitation, the threshold necessary to support a determination of eligibility.

Dr. Ballinger likewise found differences between claimant's test scores and the way he handled situations that arose in his life. She pointed out, for example, that despite relatively high scores in language, when he spoke, he used one to three word sentences, omitted words, and gestured. He also took a long time to make judgments and complete tasks. She further noted that on some days, claimant performed better than on other days.

It appears from claimant's mother's testimony that she and the CARD therapists are learning how claimant learns. They have experimented with other methods than a simply visual approach and they have been achieving some success. As Dr. Perlman said, children with autism are "quirky" and they may learn differently.

Despite the many weaknesses and deficits identified by claimant's mother, Dr. Ito, and Dr. Ballinger, claimant's standardized test scores coupled with the testimony and reasoning of Dr. Cone and Dr. Parpal compel the conclusion that claimant does not have a significant functional limitation in the area of learning

c. Self-care. Most of the testing placed claimant in the significantly impaired range. Claimant's general adaptive composite score on the ABAS-II administered by Dr. Ito was 60 and his scaled scores on self-care and home-living were 2 (the average is 8-12). The CDI in self-help and SIB-R in personal living and community living administered by the District in 2006 were very low. Claimant's performance on the VABS-Daily Living administered by Dr. Bostani in 2004 and 2006 were 73 and 75, respectively. It is only the SIB-R reported by claimant's preschool teacher to the District in 2006 which was slightly higher.

Claimant's scores on many fine motor tests showed significant difficulties, and those difficulties impacted his ability to perform many self-care tasks. Claimant has difficulty holding a pencil or crayon and thus has difficulty writing letters or coloring. He has difficulty buttoning, zipping, fastening, and so forth. He has difficulty holding spoons, forks, and knives, and is described as a messy eater. Claimant's mother's testimony, supported by the testing in self-care and fine motor tasks, established claimant had significant functional limitations in the area of self-care.

d. Mobility. There are no tests upon which to rely to judge claimant's ability in this area. Indeed, there is nothing in the statute or regulation to suggest what motor skills are to be considered. The service agency takes the position that if the evidence showed claimant could move from one place to another, without assistance, that was sufficient to establish there was no significant functional limitation. Claimant argued that cerebral palsy was a separate qualifying condition, and therefore an applicant for regional center services with a diagnosis of autism did not need to establish that degree of limitation in order to be found to have a significant functional limitation in the area of mobility. While clearly claimant was not required to establish he suffered from cerebral palsy as well as autism in order to establish regional center eligibility, he did have to establish a significant functional limitation.

The evidence established claimant could walk, run, climb stairs, play on a trampoline, play soccer, and play with others on a playground. There was no evidence that he needed assistance to perform these tasks or that he routinely suffered injuries when playing, walking, climbing stairs, or running. His mother described minor injuries he suffered, but those could be sustained by any five-year-old boy. The tests of his gross motor abilities showed he was clumsy and had poor motor planning ability. Nevertheless, claimant's deficits in those areas do not establish a significant functional limitation in the area of mobility. This conclusion is supported by the opinions of Dr. Parpal and Dr. Cone.

e. Self-direction. Claimant's scores on testing by Dr. Bostani, the District, and Dr. Ito showed significant limitations. The testimony describing his activities in school and at home are contradictory, but greater weight is given to his mother's testimony since she has had a far greater opportunity to see how he performs his assigned tasks than

others who have seen him only once or twice. Based on the testing and claimant's mother's testimony, claimant established a significant functional limitation in the area of self-direction.

f. Summary. Sections 4512 and 54001 of the Regulations require significant functional limitations in three of the seven listed areas. Because claimant is a child, the areas of capacity for independent living and economic self-sufficiency are not relevant. Claimant was only able to establish significant functional limitations in two areas, not three. He therefore did not establish he suffered from a substantial disability.

g. Major impairment. Section 54001 of the Regulations contains a requirement for establishing a substantial disability not contained in section 4512: that the condition results in a major impairment of cognitive and/or social functioning sufficient to require interdisciplinary planning and coordination of services.

Dr. Lott and then Dr. Bostani were the first to diagnose claimant with autistic disorder, but Dr. Bostani's diagnosis, as well as subsequent ones, all placed claimant in the mild range. That coupled with scores on such tests as the Stanford-Binet, WPPSI-R, and others, showed no major impairment in the area of cognitive functioning. Claimant's social functioning, however, is more problematic. Nevertheless, given the mild nature of his underlying developmental disability, it cannot be concluded that he suffers from a major impairment in social functioning.

h. Indefinite continuation of disability. Since claimant is not eligible for regional center services because he did not establish a substantial disability, it is unnecessary to further determine if his condition would be expected to continue indefinitely.

ORDER

The decision of the service agency, which determined claimant is not eligible for regional center services because he does not suffer from a substantial disability, is affirmed.

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

DATED:

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings